

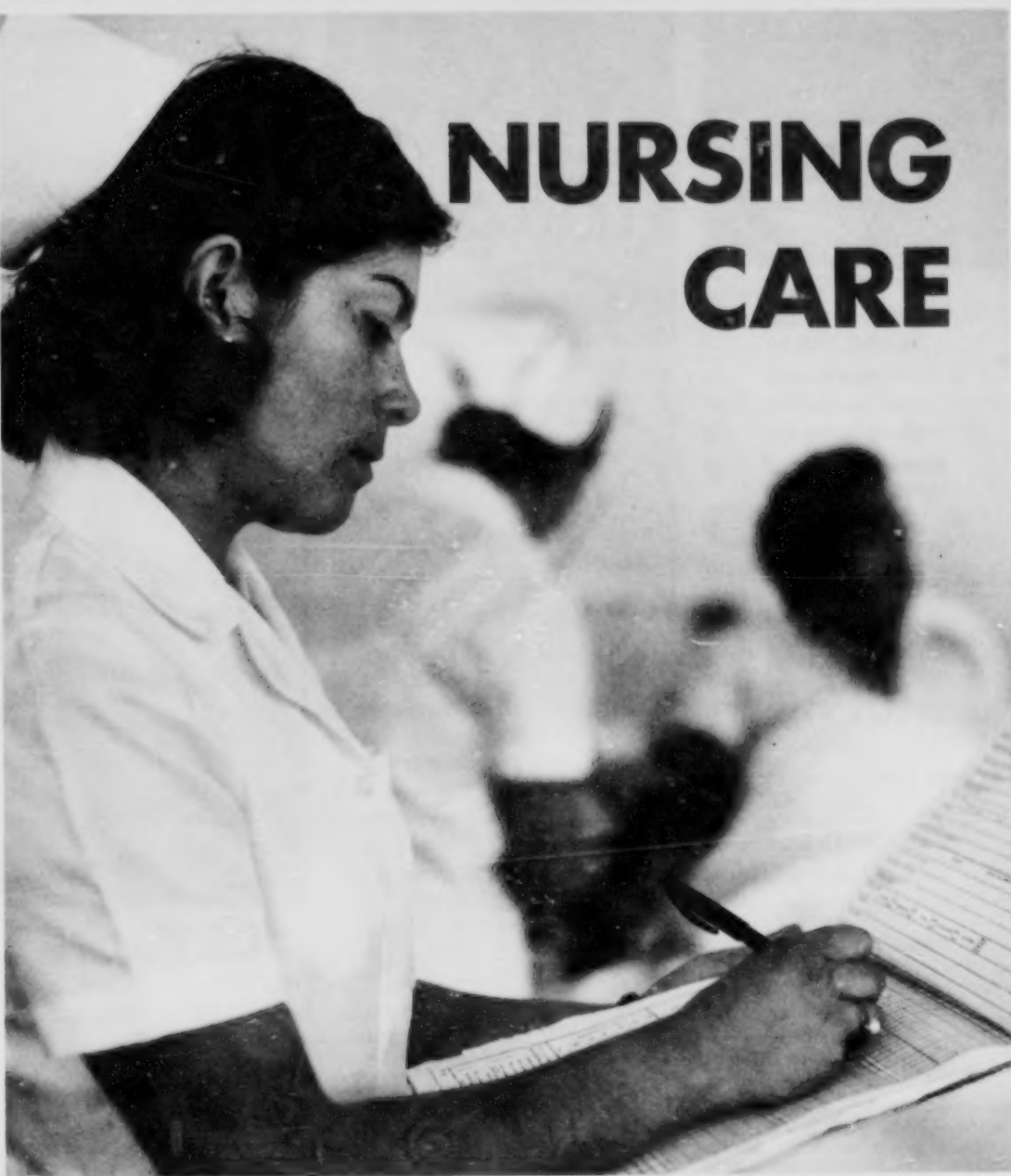
WORLD



THE MAGAZINE OF THE WORLD HEALTH ORGANIZATION

HEALTH

SEPTEMBER-OCTOBER 1992



NURSING CARE

WORLD HEALTH

THE MAGAZINE OF THE WORLD HEALTH ORGANIZATION

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Editorial

More than ever, we need nurses

Most people's image of the nurse is that of a uniformed lady caring for patients in a hospital ward. This stereotype gives a very false impression. In fact, many nurses work, and always have worked, outside hospital – in people's homes, in health centres and dispensaries, schools, factories and elsewhere. Most people are also unaware that many nurses work as senior managers and as educators and researchers. In many countries there are also male nurses. Thus, the number and diversity of persons working under the title 'nurse' makes generalization dangerous and, more practically, poses enormous problems of definition and categorization, as well as legislation and professional preparation. While a nurse in one country may be a highly educated practitioner with several qualifications and responsibility for her own actions, her counterpart elsewhere or even in her own country – sometimes called auxiliaries or nurse-aides – may have had only minimal training and have no autonomy. The answer to the question "what is a nurse?" is therefore not self-evident.

Promoting health, preventing illness, and caring for the sick are age-old human concerns, and certainly not the prerogative of any occupation. In fact, the bulk of nursing and healing is carried out not by professional nurses and their support staff, but by families and friends. Traditionally, caring and nursing in families and communities have been carried out by mothers, grandmothers, young girls or female neighbours. This is unlikely to change, and is now fully recognized by health workers everywhere. Nurses increasingly see themselves not just as active providers of care, meeting the professionally defined needs of

Nurses increasingly see themselves not just as active providers of care, meeting the professionally defined needs of passive patients, but more as facilitators who help people to take charge of their own health.

passive patients, but more as facilitators who help people to take charge of their own health. She – or he – informs, educates, and supports the work carried out in families and communities. The work of nursing staff and their training must therefore be geared to these situations and provide responses to local – and changing – needs. It must also be seen in relation to the other caring professions that have proliferated during recent decades.

In many countries, the nursing profession is in a state of crisis, resulting in lack of interest among the young to take up nursing. Until society values caring work and women's work more highly, and rewards them accordingly, measures taken to attract new recruits will not succeed; well-educated, motivated women will continue to seek careers in occupations that have a higher social standing and higher remuneration. The social consequences of this for the health and well-being of populations will be disastrous. In developing and



Dr Hiroshi Nakajima,
Director-General of the World Health Organization.

developed countries alike we need excellent nursing and midwifery services.

More than ever it is essential to clarify and agree on fundamental issues: the who, what, why, and how of nursing. Nurses, other health workers, and the communities they serve must move beyond the traditional stereotype and be flexible and forward-looking. This may sometimes be painful and difficult, but it will enable us to create nursing and midwifery services that are appropriate for the third millennium. ■

READEX
FICHE

Hiroshi Nakajima, M.D., Ph.D.

Healing a sick society

Blanka Misconiova

We had to change the system . . . Nurses and physicians were among the first to play an active part in changes which occupied everybody's minds.

For the past 40 years, the role of nursing and the status of nurses in Czechoslovakia were closely connected with the relationship of society to health and the acceptance of human rights, and showed insufficient reverence for the human being. Society was controlled by decisions of a single party which claimed to speak for the "people". All that was imperfect, diseased, or handicapped was kept out of public view as the "perfect" society strode forward to "the better tomorrow".

When in 1989 our country started on the difficult road to democracy, health and medical workers had a particularly challenging task – to change the attitude of society to health. We had to change the system but at the same time undergo a metamorphosis of our own consciousness. Nurses and physicians were among the first to play an active part in the changes which were occupying the minds of our entire society.

Short-term and long-term reform plans were developed within the Ministry of Health, involving a multidisciplinary team of workers from several specialized branches. Part of these plans included creating the post of Director of Nursing at the Ministry of Health, as well as making



Nurses and physicians played key roles in changing the attitude of society to health.

major changes in the education of nurses, defining the new role of the nurse in the health care system, paving the way for private practice, revising legislation, altering the wages structure, and so forth.

To help the weak

At the time of our "velvet revolution" the department of childhood allergies consisted of one physician and myself – a nurse – with 3500 young patients. In the evenings and at weekends I met with my colleagues in the Nurse Clubs, an organization established

since November 1989, which already had 14 000 members. What we have in common is the desire to help our country, to help the weak, the sick and the depressed. Our sick society was grateful for this assistance as people began to realize how big is the debt owed to those who care for the old, diseased and handicapped fellow citizens who used to be kept away from public gaze.

In November 1991 I was appointed Director of Nursing and, within the framework of the Ministry, I became a member of the team responsible for setting new priorities and radically changing the existing health care

system. To strengthen the role of the rank-and-file nurses, regular seminar training of nurses was started by the Ministry of Health. The training courses focus on innovative approaches to and management of nursing, and communication with the patient and within the team.

Every week, in one of the eight regions of the Czech Republic, I meet leading nurses and try to solve the specific problems of the region. These meetings keep me in direct touch with routine practice and enable me to assess on the spot the impact of the reforms. I do random check-ups on all kinds of nursing activity, and all the medical facilities have become used to my unexpected visits – which won me the nickname “Big Sister”.

From the very beginning I was concerned that nurses should have the maximum level of knowledge. Where they were not adequately informed, I appealed to their superiors to establish an information network within the facility.

Important changes in legislation relating to health called for the role of the nurses and of secondary medical staff to be defined unambiguously. We took advice from the professional organizations of nurses and other health staff as well as from the doctors' and specialists' associations. In particular, I worked on the draft

principles of an Act, together with a few enthusiasts who realized the necessity of giving institutional status to the professional protection of nurses. So we managed to bring about a big improvement not only in the status of nurses in society but also in their salaries. The federal law on wages was a hard nut to crack, but all departments of the Ministry of Health gave me their support and we managed to increase the salary of nurses by an average of 30%.

Hitherto the whole territory of nursing had been underplayed, and particularly research in the field of nursing was neglected. Even today it is very difficult to motivate the nurses for research tasks because they are afraid of their lack of competence. Our education efforts put the greatest emphasis on self-education, and there are regular tests of nurses' qualifications. Seminar training courses and information meetings on new forms of nursing care, such as home care, home help, hospices and nursing homes, are organized through the medical councils of the district offices.

Today the status of nursing in the Czech Republic is very favourable. A nurse can be active in the state or private sectors, or she can be an independent provider of nursing care or an active member of a multi-

disciplinary team. Nurses have a professional organization which cooperates closely with the trade unions and the Ministry of Health, and which will protect their rights as well as the rights of patients. A nurse now has a free choice whether to improve her qualifications, and can take an active part in the changes now occurring in society. She can travel abroad and apply the knowledge gained there in her work. Above all she can dream about the future and have faith in the human intellect's capacity to diagnose correctly and set about curing successfully our sick society. ■

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We had a common desire to help our diseased and handicapped fellow citizens.

The traditional birth attendant

Imtiaz Taj Kamal

In early 1955, a young woman returned from England to her homeland, Pakistan. She was equipped with diplomas to practise nursing and midwifery. She had learnt to give care to pregnant women and to deliver babies in the hospital and in the home. Full of enthusiasm, she was going to practise midwifery the way she had been taught.

There were no trained midwifery tutors in the country. So she taught midwifery in a WHO-supported school of public health for training health visitors. Pregnant women were very good about visiting the clinic for antenatal check-ups. While the tutor and the students waited with their equipment ready, not many calls for delivery came. Babies, however, were born and the mother would appear with a babe in her arms. When asked

Her mission in life was changed from extinguishing the TBAs to working with and improving the dais in several countries.

why she did not send for the midwife, the reply invariably was, "The baby came too quickly."

The young woman was frustrated. She was puzzled. She was confused. And she was angry. All babies cannot come quickly in Karachi. One day her husband, a research scientist, suggested, "I am sure there is an explanation. Why don't you find out why the mothers do not call you when the time comes?" Within a month she found out that ALL the babies that had reportedly come too quickly were

delivered by the *dai* (the traditional birth attendant or TBA).

She was shocked and depressed. She, with all her training, was ignored, and an illiterate, untrained, old and dirty-looking *dai* was given preference over her. Her reaction was typical of the medical profession even today. She made it her mission in life to extinguish the TBAs. Again she met with failure. Again her husband advised her: "Your school covers only a few thousand population in a one-mile radius, where perhaps 400 babies are born every year. Even if you succeed in clearing this area of the TBAs, what about the rest of Karachi? What about the rest of Pakistan, where 80% of the population live in villages where there are no hospitals or doctors or trained midwives?"

Gradually she realized that she was



Traditional birth attendants being trained in Karachi.

not only defeated but had been blind, ignorant and unrealistic. She faced the bitter truth. She could not beat them so she had to join them. It took almost a quarter of a century of honest effort. Among the many lessons she learned were:

- In the next 50 years, no developing country will have enough health manpower to cover the entire population; TBAs will continue to exist.
- TBAs may be illiterate but they are not stupid.
- Not all TBA practices are dangerous, otherwise the developing world would not have an over-population problem.
- The TBA enjoys greater confidence within the community than the modern registered midwife; her ways are not alien for the family.
- A friendly TBA can provide entry to homes and communities, while a hostile TBA, with one stroke, can undo months of efforts by the trained health care provider.
- Above all, the TBA is an available human resource. If properly trained and supervised she can be invaluable not only in reducing maternal and neonatal morbidity and mortality, but also in promoting breast-feeding, immunization, healthy eating habits, and family planning.

She changed her mission from extinguishing TBAs to working with and improving the *dais* in several countries of the region. She was laughed at, even given the nickname "Godmother of TBAs". Looking back, this professional nurse midwife, not so young any more, nostalgically recalls with respect and affection and not without satisfaction:

- the dozens of curricula for TBAs that some like-minded colleagues struggled through to help the TBAs to increase the safety of their midwifery practice;

- the TBAs of Harran-Al-Awameed in Syria who, after training, showed results within three months by functioning as problem-finders and motivators as well as providers of authorized services for antenatal care, immunization, family planning, oral rehydration, and general health education for healthy living;
- the TBAs in the Palestinian refugee camps in Jordan who were so well trained that they could teach a thing or two to a freshly graduated midwife;
- the TBAs of Faisalabad, Pakistan, who have been the major factor in reducing the maternal mortality there from 7 to less than 1 per thousand births.

The kaleidoscope of memories is not all of brilliant colours. There are dark spots of horror and tragedy too: the malnourished mothers who were told by the TBA not to eat much during the last three months of pregnancy because "the baby will get too big"; the babies who died inside the mother because the TBA waited too long, or died after birth from tetanus; the girls aged under ten in certain countries with severe sepsis

after female circumcision. Hence the collage is a mixture of brilliance and darkness. Fortunately there is every possibility of decreasing the darkness of dangers and tragedies by proper training, effective use and regular supervision of the practising TBA.

Will the TBA last for ever in the developing countries? The answer is, "No". The last 25 years have proved that TBAs will die a natural death wherever maternity care providers become available, accessible, affordable *and* acceptable to the community. ■

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A traditional birth attendant counsels a couple on planned parenthood

Chile's rural nurses

Isabel Ringeling & Gerardo Herrera

Our visit to Til Til confirmed the immense professionalism and enthusiasm of the public health nurses working in the remote countryside of Chile.

Observing the work of a rural nurse within the health system of Chile is a real challenge for anyone who wants to understand her role and her contribution towards improving the level of health of the rural population.

Til Til, a traditional Chilean village 30 kilometres from the nearest town, is where two such nurses, Francis Molina and Jessica Pinto, work. To reach it involves crossing a beautiful valley rich with farms, grazing herds and even mineral resources (though they are very little exploited). The drive to the village is on dirt roads and crosses the River Polpaico, which in rainy winters regularly leaves a large part of the area isolated. The community has 12 677 inhabitants within an area of 650 square kilometres. Some 4500 people are concentrated in the village of Til Til itself, and another 3600 in several small communities with no more than 600 inhabitants each. The rest of the population is scattered. The indicators reveal the vulnerability of the population to major health risks: 11% are illiterate, 10% live in extreme poverty, 19.4% of children aged under six years are at high risk from disease and 12.9% of the same group suffer from malnutrition, 34.6% of pregnant women are underweight, and 8% of all children were born with low birthweight. All these indicators are higher than the national average.

To arrive at the Hospital of Til Til,



At the health post, the nurse monitors the nutritional status of young children.

we cross the village, which does have electric lights, a sewerage system, drinking water and telephone, thanks to the programmes of rural development which the government has carried out with international support. The people live principally from farming, which has been modernized and diversified; so they have switched from growing mainly fruits such as olives and prickly pear, which thrive on the dry soil, to cultivating grapes and other fruits for export. This labour generates seasonal employment with all the advantages and drawbacks which that signifies for the economic stability of the families.

They also work as miners, either individually, in the constant hope they will strike it lucky, or for a large extracting company involved in producing cement and stones.

The Til Til hospital performs mainly primary health care activities, also serving other remote areas. The main health problems in both children and adults are respiratory diseases in

winter and digestive problems in summer. Cardiovascular disorders are also important in adults.

During her rounds of the local neighbourhood, Jessica undertakes regular visits (weekly, fortnightly or monthly depending on the distance) to the health posts, together with the doctor, the matron and the dentist whenever possible. In each post an auxiliary nurse lives permanently, hard at work and coordinating her activities with the other sectors concerned with community development. The work done by these rural health posts conforms to a national programme which puts special emphasis on the focal points of hazards to health, and is supervised by the nurse. The rest of the team contribute by overseeing specific activities. To meet the health needs of the communities with less than 300 inhabitants and of the scattered inhabitants, Jessica has to go out to meet them at the so-called rural nursing stations, which are places

arranged by the community as consulting rooms, usually in the community hall or in a classroom of the local school.

One sunny day in the month of August we went with Jessica on her rounds to the posts of Polpaico and Huertos Familiares, some 15 to 25 km from Til Til. In the far north and far south of Chile, where people live in extremely isolated conditions, the health posts and rural nursing stations are so far apart that to make the rounds involves using a variety of means of transport: light aircraft in Aysen, motorboats to cross the channels and reach the many islands of the south, or four-wheel drive vehicles to get up to the villages of the northern altiplano. In such cases the rounds can last five days or more and the nurse has to sleep overnight at each place.

In the posts that we visited we could appreciate the work that the nurse does: acting as a team with the auxiliary nurse, diagnosing the total health situation of the community, paying special attention to health promotion, prevention and treatment of diseases, treatment of chronic patients, epidemiological surveillance

of communicable diseases, education of the community, home visits to families, and coordination with the community organizations and local institutions.

We were shown sketch-maps of the community on which all the houses of the sector were identified; different colours showed where families lived with different grades of risk (e.g., latrine close to a drainage ditch, an unprotected well, a chronic invalid, an illiterate mother and so forth).

The numbering of the houses on the map coincided with the numbers on such official forms as the family survey, the summary of family surveys and the classification of family risk – basic tools for planning the work of the nurse as well as the auxiliary nurse. As we watched, Jessica set to work checking the growth rate and development of children, vaccinations, delivery of milk and all the corresponding educational activities. We saw with what care she filled in the registry forms and noted down each individual and family who had had attention.

The knowledge that nurses who work in the rural areas have gained of

the problems faced by the community encouraged them to contact certain nongovernmental organizations and initiate a new educational project which is contributing positively to integrated rural development – that of hydroponic farming of vegetables, which will permit families to improve their diet.

Our visit to Til Til was highly rewarding, and we were able to confirm, once again, the immense professionalism and enthusiasm with which the public health nurses of Chile are carrying out their work in the remote countryside. ■

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Til Til Hospital serves a large rural area in Chile.



In the waiting room, educational posters "talk health" to the patients.

"Miss, we cannot read or write"

Maureen Minden

After training, traditional birth attendants in a remote part of Nepal are passionate in their desire for better treatment of girl children.



Monitoring pregnancies is a key element for mother and child survival.

Nepalese women say that "in childbirth, death comes for women". After a successful birth they say "I survived". Maternal mortality in Nepal is under-reported at a figure of 8.5 per 1000 births; a study two years ago in Kavre assessed it at 12.1 per 1000. Infant mortality is more than 123 per 1000 live births.

For the past three years in Kavre, a middle-range mountainous district in Nepal, auxiliary nurse-midwives and I have been teaching maternal and child health care to village women. Divisive factors seem to overshadow the commonality of human needs; the mountain terrain, ethnic and language differences, the caste system, gender discrimination and illiteracy – all these seem to fragment our efforts to spread health education.

As a member of the British Voluntary Service Overseas, I work

within the government health care system as a district public health nurse. There are nine health posts, the most remote requiring two or three days' walk. Under the Division of Nursing's traditional birth attendant (TBA) training programme, we have taught at all of the health posts: 15 women at each post, one trained TBA for every two to three villages. A drop in the ocean, but a beginning!

The programme involves a ten-day basic course, a four-day refresher course within a year, and six two-day supervision meetings every month. The women are illiterate. The training is minimal, designed in the face of such constraints as: limited funding; no staff at some health posts; no roads or transport in most of the district; some TBAs living two to three hours' walk from the health post; and women tied to the home and the land – with

planting, monsoons, and harvesting from June to October.

Cultural beliefs and practices vary, but in Kavre certain views seem to prevail, the most influential being that menstrual blood, and consequently the blood of childbirth, is a source of pollution. Very often women give birth alone, thereby not polluting anyone and avoiding the obligation to give gifts and do purification rites.

The mother-in-law is traditionally the birth attendant for her daughters-in-law. Sometimes she attends only the first birth, the women giving birth alone after that. Some, having gained a reputation as wise, may be called by other families in the community if a birth is difficult or complicated. Prior to taking the course, with no knowledge of the germ theory or sources of infection, TBAs used to advise women to give birth in the

animal shed to avoid polluting the home.

Since there is no knowledge of the uterus and its functioning in labour, a cloth is tied tightly around the abdomen to prevent the child from "going upwards into the mother's heart and killing her." If the placenta is not delivered within a few minutes, the woman's hair is pushed down her throat to make her vomit in the belief that this will help her to expel the placenta. After birth there is no effort to control bleeding; this "bad blood" (menstrual blood of the months of pregnancy) must come out!

Nutrition is a serious problem. Many foods are restricted in pregnancy as harmful, including oranges, tomatoes, pumpkin, honey, and sometimes green leafy vegetables. The connection made between the pregnant woman's nutritional status and that of the baby growing within her is obscure. The postnatal diet is white rice, herb broth, and ghee (clarified butter); everything else – legumes, peas, green vegetables, fruit, milk, and yoghurt – is withheld. The mother's intake of water is severely restricted since it is thought to give the baby stomach pains.

At the beginning of the course, the TBAs and I discuss our different



A doll used in training TBAs

backgrounds. They tell me, "From when we were little we never had the chance to go to school; Miss, we cannot read or write". We discuss their experience and skills, based on their care of families, homes, fields and animals. After a few days of classes, they say "Look at us. Who would have thought we would be

getting education!" As they develop some understanding of our bodies in health and illness, and aspects related to childbearing, they begin to believe that perhaps, even in Nepal, so many women and babies need not die and they themselves could be instrumental in improving health.

The Division of Nursing's programme has developed flipcharts and a teaching manual for village level, but demonstrations, directed discussion and role-playing bring the information alive. The TBAs are passionate in their desire for better treatment of girl children. Today they advise pregnant women about nutritional needs during pregnancy and after the birth, as well as the need for tetanus immunization, giving birth in a clean place, management of labour, early recognition of problems, safe cord-cutting techniques, early care of the baby, family planning and much, much more.

These TBAs are eager to share their experiences, and sometimes thank the district nurse-midwives, who are now their role models, for clarifying some problems they have long struggled with. They tell them, "You teach us. We can improve life in our villages." ■



Learning how to read and write: a right long denied to Nepalese women

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Helping families to cope

Tamar Krulik & Skira Katz

On 18 June 1991 I received a telephone call from a woman who was anxious because of constant screaming and shouting from her neighbour's house. Knowing that the neighbour, Mrs Aliza Alon, was finding it very difficult to cope with her three small children, and that the public health nurses visited homes and helped families to cope in time of stress, she felt that maybe I could help the family.

Unfortunately, the Alon family was not registered in the family health clinic, although this is free and very widely used by the public in Israel. I decided to go directly to the family, who lived in a small middle class residential area.

Aliza, who recognized me as a public health nurse in the neighbourhood, seemed surprised yet somewhat relieved to see me and invited me in. I found the house to be in complete disarray. She immediately apologized for the mess and added that she did not seem to have either the time or the energy to clean and tidy up. This 27-year-old mother lived with her husband and three children and her own elderly, hemiplegic mother who was totally dependent on the daughter for her daily care. Aliza's husband, a travelling salesman, was always on the road, so the main responsibility of taking care of the family fell on her.

Three months previously, the second child, Adam, aged 4, was diagnosed as suffering from diabetes. This additional responsibility (involving daily urine tests, special diet, follow-ups in the diabetic clinic and daily "shots") proved to be too much for Aliza. She became physically and emotionally exhausted, with a low level of energy and tolerance to cope with the daily routine. She was irritable with the children, and expressed her feelings

with a great deal of emotion and tears.

I described to Aliza the services I could offer her through my work at the family health clinic. Although still a bit hesitant, she agreed to accept my offer. Together, we identified the family's problems and drew up a care programme. This included:

- weekly home visits by the public health nurse to provide Aliza with guidance, information, reinforcement and support in her efforts to cope with Adam;
- putting Aliza in contact with self-help groups for families with diabetic children, so as to decrease her feelings of frustration and improve her coping skills;
- referral to social services so that a qualified helper would be sent to care for the mother, while volunteers from the neighbourhood would help look after the children;
- visits to the family health clinic for medical and other examinations and follow-ups for the three children.

The main role of the public health nurse in Israel is preventive, but she also has to intervene directly with families, especially where there is a chronically ill child or old person.

Preventive role

This report from a family health clinic in Israel illustrates the role of the public health nurse in the care of a family with a chronically ill child. The main role of the public health nurse in Israel, however, is preventive. This includes prenatal care of the mother and care of the child from birth to the completion of high school. The services for the children are organized according to different age groups and specific health needs.



Knowing how to listen enables nurses to give their help effectively.

The most intensive care is provided in the first year of life, when the mother and child visit the family health clinic about eight times. Thereafter, the visits become less frequent. There are standard plans and goals for all the visits to the clinic, plus additional guidance and care to satisfy the needs of each mother and child. It is the policy of the service to make a home visit to every newborn infant, and additional visits if needed.

Among the activities included in the services are:

- evaluation of the physical, mental, cognitive and social growth and development of the child;
- early detection of impairments and defects; referral for diagnosis and rehabilitation when necessary;
- immunization against infectious diseases (diphtheria, pertussis, tetanus, poliomyelitis, and measles);
- guidance for parents and care-givers to help them develop the child's potential abilities on an individual and group basis;
- working in close cooperation with other related services in the community (psychology services, department of welfare, schools and so on);
- follow-up of children with special needs and health problems.

The work of the public health nurse in Israel is challenging, ever-changing and dynamic, especially in an era of major immigration from countries such as Ethiopia and Russia. Indeed, these nurses have made an important contribution towards decreasing infant mortality, improving preventive measures and promoting better health among the new immigrants.

Today, Israel's national and child health services no longer focus on preventing infectious diseases and lowering infant mortality rates. Instead the focus is more towards the wider aspects of community care, with particular emphasis on effective intervention with families with chronically ill children and old people. Indeed, the public health services foresee the development of paediatric and geriatric clinical nurses who will be specialists in chronic illness. ■



Health service staff giving family life counselling in Israel.



A child with Down syndrome receives attentive nursing care.

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Home care in Denmark

Slim Allagui



Even when they enjoy good health, old people often need help in their daily activities.

The home nurse is the key personality in Denmark's policy for the elderly.

The alarm clock goes off at half-past five in the apartment of Stine Nielsen, a 25-year-old home nurse, in Frederiksberg, outside Copenhagen. She prepares breakfast for her six-year-old son Peter, and a sandwich for him to take to the kindergarten. One hour later she gets on her bicycle, leaving her husband Jan, a biologist, to feed and dress the child.

Stine starts work at seven o'clock in the communal centre for home care in Frederiksberg. The centre has 90 nurses, 41 auxiliary nurses and 552 house cleaners to look after some 5000 old-age pensioners, who are for the most part in good health but have to be watched in case they need help in their daily activities. In her office, Stine organizes her working day between 7 and 8 a.m. "I make between 10-15 home visits each day so they have to be planned almost by

stopwatch – efficiently but without forgetting the vital human aspect, so that the pensioners don't get the impression they are being visited by some pre-programmed robot."

She goes on: "There are two categories of pensioners, those who are basically well but need help every day – to take their medicines, to remind them that it is important to eat and drink, and so on; and the others who are sick, but have either family care or are not so disabled that they need to be in hospital or have to end their days in a rest home."

The home nurse, a century-old institution (in fact 101 years old) in Frederiksberg which was originally administered by a group of nuns, is the key person in Denmark's policy for the elderly. That policy rests on a simple philosophy: "To let the elderly live as long as possible in their own environment, because they feel better

there and the cost is much lower for the community which is financially responsible for them."

Stine and her colleagues are the ones who decide whether the pensioners can continue living in this "more human" manner, or if they should consider going to a rest home where residents are mostly aged over 80 and have greater need of care. Frederiksberg has 6503 such old folk; 163 of them are over 100 – mostly women.

On her bicycle, with her nurse's bag on the luggage-rack, Stine sets off on her first visit – to the Tenberg couple, childless and in their eighties, living in an attractive three-room flat beside the royal park of Frederiksberg.

The husband, Arne, opens the door with a welcoming smile for Stine – the only contact he has with the outside world. "How is Ada?" she asks. "Not too bad," he replies. "But she is

complaining and I can't find out why, perhaps because she has to go to the dentist tomorrow and she hates that." His wife Ada, totally paralysed for the past four years, sits in an electric wheelchair and contemplates the flowering trees in the park. Stine tenderly takes her hand. "Don't be afraid, Stine is here," says Arne to reassure her. Ada has difficulty pronouncing words intelligibly.

For four years, Arne has been a reluctant prisoner in this apartment. "When Ada first got ill, I thought I would be able to manage on my own, but then her condition worsened. They suggested putting her in an old pensioners' home but I refused; you can't put away someone with whom you have spent 55 years of your life," he confides, stroking Ada's newly washed grey hair.

"The Tenberg family gets three visits a day from the nurse and auxiliary nurses", says Stine: "one in the morning, one in the afternoon and one in the evening, to help Ada to take a bath, watch over her health, dress her and put her to bed."

A house-cleaner paid for by the commune comes twice a week for two hours to clean up. "That's the only time off that I get," says Arne, who is

getting ready to run some errands, pay bills at the post office and do some business at the bank. Three times a week the couple receive some frozen foods. "The rest of the time I prefer to do the cooking myself, because Ada loves the tasty little dishes that she used to make." With every sign of appreciation, he adds, "The home nursing system is the only thing that helps us to stay together."

In the house, the commune has provided the couple with three wheelchairs, an electrically-operated bed, a bathroom specially equipped for the handicapped, and a little electric lift near the staircase for their rare trips into the town – for blood tests at the hospital or to the dentist.

In the evening, the nurses exchange their bicycles for the seven red service cars, each with a telephone linked to the ambulance services. "There are people with cancer, people with AIDS, people seriously ill, who would rather die at home and who have to be watched 24 hours out of 24," explains Mie Mogensen, one of the two people in charge of the Frederiksberg home-care centre. With 27% of people aged over 67 in a district of 86 000 inhabitants, the home nurses are kept busy working in

three shifts right round the clock.

"As people are living longer, there is going to be more and more need for home care," she forecasts, adding, "the present system functions well, even if certain patients sometimes grumble that they see too many different faces of the staff and would prefer to get to know just one who would become part of the family and of their everyday life. We may have to re-model our system to respond better to the needs of the next generation of the elderly. But the system we have now, for all its drawbacks, is the best we have found so far." ■

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Nurse Stine sets out on her round of home visits.



For the old couple confronted with disease, the visiting nurse is part of the family.

Life for its own sake

Whether in health or in sickness, life is worth living. This is the challenge of nursing. When the doctor issues a warning: "stop smoking", or a diagnosis: "you have diabetes", or a treatment: "take this pill three times a week", the message is clear enough but we do not know exactly what the next step may be. The role of nursing is to help us stay healthy, to find the way out of disease or, if this is not possible, to put up with disease and lead a life that is as normal as possible.

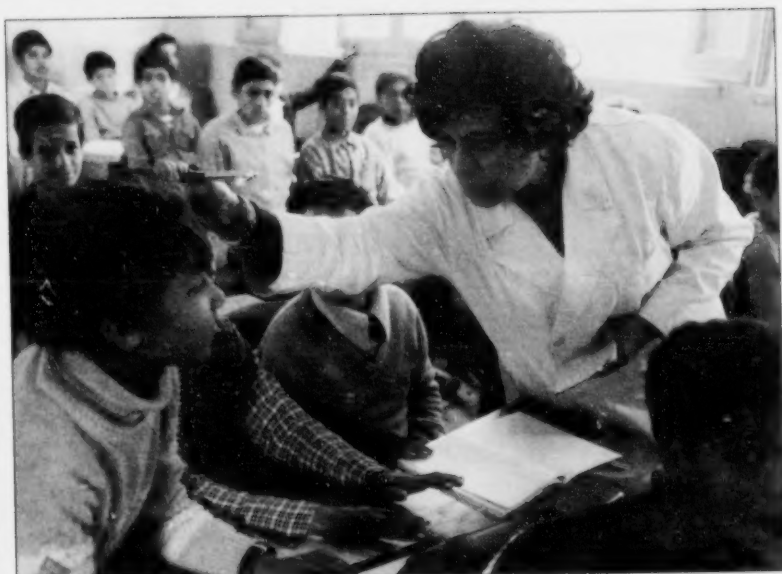
People may be confronted with practical problems that seem impossible to manage: how to ensure that a child with diabetes does not accept sweets offered by friends or neighbours? How to engage in a busy professional and social life and yet maintain a healthy diet? How to

ensure that a very old person living alone will remember to take vital drugs regularly?

These are a few examples of the many areas where nursing and nurses are needed more than ever. At the hospital or in the home, they have an irreplaceable role to play in dealing with symptoms and treatments, in supporting family members to fight fears and alleviate physical strain that may be caused by disease, in organizing the resources – whether of money, time, or social support – that will be called for in the event of sickness, in helping people to accept their limitations and yet to live life to the full.

While basic scientists and physicians are engaged in a ceaseless struggle against age-old or "new" diseases and health problems that afflict human beings all round the planet, nurse researchers explore new and better ways of remaining well, or improving the quality of life in face of disease and disability. And in the health care services nurses are the front-line soldiers who fight for life. They are the advocates of life in spite of all setbacks, of life for its own sake. ■





Around the world, nurses are active in all areas of health care.

Facing page: As a maternity ward nurse, and as an assistant to the surgeon.

Above: Consulting the records of patients in Singapore, and monitoring the health of schoolchildren in Egypt.

Right: A male nurse immunizes a child in Mozambique.

Below: Tending a premature baby in Tbilisi, Georgia, and providing health education in Bangladesh.



Normandy helps Senegal

Brigitte Girault & Badara Samb

An initiative backed by the Municipality of Caen, a city in Normandy, northern France, is helping a district of the West African state of Senegal to overcome disease and malnutrition. In 1988 we studied the health situation in the Department of Oussouye under the auspices of the "Normandy Association for Social Aid to Senegal Villages". This showed that, despite seven years of health work, living standards in the district had scarcely changed, and people were still plagued by malnutrition and by diseases related to the environment, such as malaria, diarrhoea and parasites.

An innovative strategy was needed to improve the situation, consisting of an approach based on the family and what the family reported about itself. Primary health care had to be viewed in a global context and not just selectively; only failure would follow if well-meaning health workers restricted their activity to setting up basic health units, fencing off water sources and vaccinating people. Yet to do more than this would take a great deal of courage, since the work is both enormous and difficult. What became the Boucotte Primary Health Care project lasted 18 months and involved virtually redefining the word Health.

Education for health

In the preparatory phase, the project leaders studied the monthly reports from the health post in the village of Boucotte (population, 1500), made a census of the local population, visited every family to explain the aims of the project, observed the social and economic realities of everyday life, and tried to persuade everyone to participate. They drew up a record-card for each family starting with the names of father and mother, and

This project, linking environmental health closely with health education in a mainly rural area of Senegal, won for the two authors a share in the 1992 Sasakawa Prize for outstanding innovative work in health development.

including such items as the cleanliness of the home, how drinking-water was stored, whether there was a latrine, and whether people were receiving antimalaria drugs.

The next phase involved making people better aware about what they could do to improve health. Young people were organized into "hygiene brigades," which undertook to clean up the village and cut down weeds, and also to educate people. They were given machetes, rakes and brooms to keep the villages clean, and wheelbarrows so they could collect and burn rubbish.

We prepared a booklet called "The lesson of health" to serve as a basic teaching tool and to make every schoolchild a vehicle for information and health education in the family context. The Ministry of Education seconded a teacher to oversee this aspect.

Women had special responsibility for keeping each house clean inside and out, for looking after the water storage, feeding the family, and keeping wells unpolluted. The men, as heads of households, had to give their agreement so this involved them in everything to do with improving the life of the family, including construction work on wells and latrines. The Normandy Association gave each family three sacks of cement for this purpose.

In each family, people learnt about basic hygiene – washing hands, keeping water clean – and were taught how to use a simple first aid kit. Dietary advice included how to feed people who became ill. A second set of cards recorded the names and ages of children aged up to 14, pregnant women, and how much chloroquine to take each week to combat malaria, according to age. A family member



Sharing know-how for better health: Brigitte Girault works among the villagers.

was made responsible for buying and distributing chloroquine on a weekly basis and keeping the record-card up-to-date.

The success of these activities was easily measurable. There are now 90 wells to serve 111 families; 97% of the families have proper water storage and 90% use latrines. In terms of cases of disease there was a spectacular improvement, as the figures show:

	1990	1991
Malaria	3362	772
Diarrhoea	460	111
Parasitic diseases	267	98

So the diseases linked with the environment have clearly declined, thanks to a combination of hygiene measures, the building of latrines, water chlorination and the distribution of antimalarial drugs. All these steps, when backed up by a strong campaign of public awareness-raising and health education, have proved highly successful.

The factors that have helped to boost this project include community participation, the willingness of young people to take part, and the community's readiness to apply time and labour in building latrines and health posts and maintaining the antimalaria record-cards.

The negative factors included an unwillingness to change the traditional

diet – for instance, a reluctance to eat eggs – or to distinguish between what is essential food and what is merely seasoning. Such attitudes will take a long time to change. The nurses working in this district have to change their ways of operating. They can no longer be content simply to treat the sick; they have to come out of their dispensary and become real activists in the domain of health education.

In Africa, many disease-causing agents are intimately linked with the difficult living conditions, which in turn reflect the state of development. Faced with such pressing realities, it is a paradox to have health structures imposed by Western countries that have no relationship with what goes on in a village or in an over-populated township. Health does not reside in structures, in cures and in vaccinations, but rather in a whole complex where development and health education are the principal constituents. Today's goal is to ensure that health care – part of the strategy for global development – is not left solely to the "health technicians", but becomes a daily concern and daily practice for all societies which have adopted that strategy. ■



A clean container will ensure safe storage of water.



Young people launch a sanitation campaign in the village.

Mrs Brigitte Girault is a founder member of the "Normandy Association for Social Aid to Senegal Villages" which promotes and finances the Baucotte Primary Health Care project. Her address is 20, rue Saint-Norbert, 14000 Caen, France. Mr Badara Samb is Head Nurse at Ziguinchor Hospital in the Department of Oussouye, Senegal.

When special care is needed

Ellen B. Rudy & Barbara J. Daly

A Special Care Unit for chronically critically ill patients in Cleveland, USA, is proving its worth in terms of both the outcome for patients and the cost savings.

The most costly area of the hospital in the USA is the intensive care unit (ICU). The increased availability of technology for physiological monitoring and life support has created a situation where many critically ill patients who only a few years ago would have died are now kept alive for long periods of time. Although the typical ICU patient is assumed to stay for only three or four days in the unit, more and more patients are having prolonged stays. These long-term patients, labelled as "chronically critically ill", generally fall into two categories: those whose primary disease condition has no definitive cure, but who have tremendous demands for care, and those who have received definitive medical therapy for their primary

disease but still require intensive nursing care to recover (such as patients with chronic obstructive pulmonary disease, who have difficulty in breathing without a ventilator).

Recognizing the enormous financial burden to hospitals, the labour-intensive care required, and the lack of any real commitment by either the medical or nursing staff to provide the continuity of care required by the chronically critically ill, we decided that a nurse-managed unit should be designed to better address their needs. With the support of the hospital administration, we designed a Special Care Unit (SCU) for these patients. It has the following features: an environment that has as little technology as possible, where family



A nurse, who is at the same time a "case manager", can bring much relief to a person who is chronically ill.

members can visit at any time and even stay overnight; a unit where each patient has a nurse "case manager" who plans and implements the care, using treatment protocols developed collaboratively by the nursing and medical staff; and a management model whereby the authority and responsibility for managing the work rests with the nurses.

Our SCU is a seven-bed unit which opened in 1989. We are at present randomly allocating patients who are considered "long-term" to either the SCU or the traditional ICU. We are comparing the patients on length of stay, mortality, complications, readmission rate, patient and family satisfaction, and cost of care. And we are also comparing the impact on the nurses concerned, in terms of satisfaction, turnover and absenteeism.

To date, we have data on 144 patients (96 in the SCU and 48 in the traditional ICU). So far in 3½ years of operation, we have identified striking differences between the two units in terms of mortality and cost of care. The patients in the SCU were similar to the long-term ICU patients with respect to level of illness, age and medical diagnosis. However, only one-third of the SCU patients died before discharge from the hospital, while one-half of the long-term ICU patients died. While certainly encouraging, we believe this difference must be interpreted with caution in view of the small number in the ICU (control) group. Nonetheless, we believe this finding demonstrates clearly that these chronically and critically ill patients can be effectively managed outside of a high-tech environment by nurse case managers who allow the active involvement and participation of family members. In other words, the initial fear that these patients would die without immediate access to ICU technology and outside the watchful eye of the medical resident is unfounded.

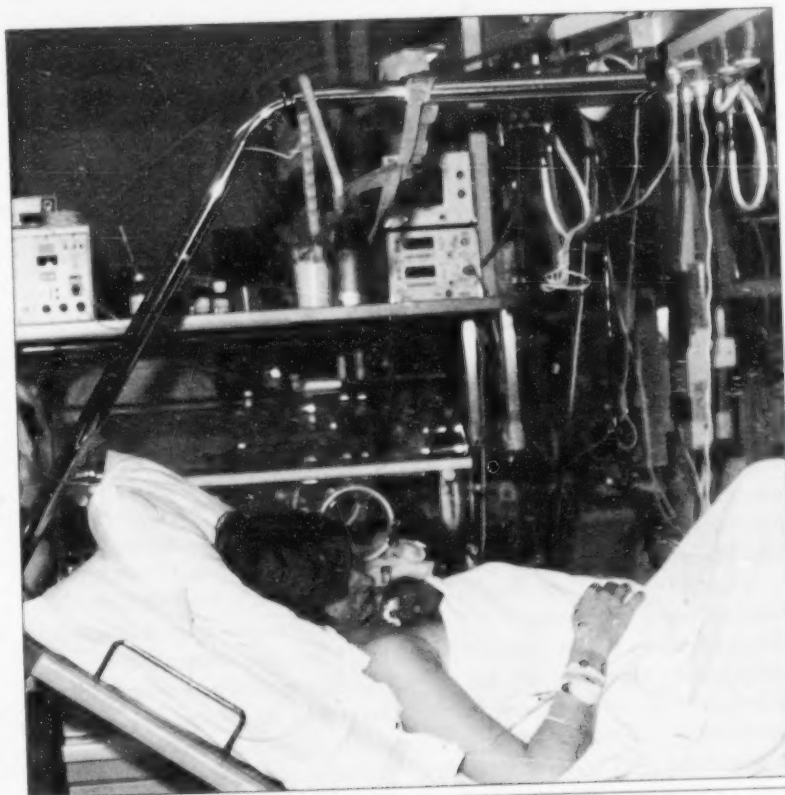
Comparison between the two groups on financial data revealed several significant differences. When we measured the actual costs to the hospital, the patient's hospital bill, and

the reimbursement or payment received for services, the results can best be summarized by saying that the average SCU patient had a positive cash flow for the hospital of US\$ 1313 (difference between cost and payment) and the average ICU patient had a negative cash flow of US\$ 11 066. When the groups were compared by charges for specific services, the SCU patients had lower charges for X-ray, laboratory and respiratory therapy services than the ICU patients. The nurses in the SCU do not allow "routine" X-rays or blood tests unless they feel there is clinical evidence of their usefulness; this too results in lower laboratory charges.

In summary, the concept of creating an alternative way to care for a costly and increasing group of chronically ill patients has merit in terms of both the outcome for patients and the cost savings. Too often, alternative ways of providing care are

not tried for lack of administrative support, or are never really subjected to any rigorous testing of patient outcomes. At the University Hospitals of Cleveland, we are continuing a four-year study to measure the success or failure of the SCU in meeting the special needs of the chronically critically ill patients. We believe we are already on our way to changing the way these patients are cared for. ■

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The ideal nursing environment has as little technology as possible: is this young mother with a premature baby really comfortable with her surroundings?

Fresh hope for Paraguayan mothers

Maggie Jones



Children going to school. Literate mothers are much more capable of looking after their own and their children's health.

Political changes sweeping through Paraguay offer hope of changes which will profoundly affect the lives of women, but especially their health. Paraguay has one of the highest rates of maternal mortality in Latin America – over 300 deaths per 100 000 live births – due to a lack of antenatal and obstetric care, poor family planning services and a total ban on abortion.

Since 1989, the government has been pursuing a policy of democratization. A new constitution is being drafted which will increase women's rights in many areas, and the government is strengthening its maternal and child health programme with a family planning component.

Unlike most Latin American

countries, Paraguay has a predominantly rural population. Sixty per cent of the people live in rural or semi-rural areas, and the cities are comparatively small, lacking the huge shanty towns which are so characteristic of other capitals in the region. Nevertheless, the divide between urban and rural is a big one. While the capital, Asunción, has a modern water supply system and the tap water is safe, only 8% of people living in the rural areas have access to health services, women in the countryside may have to walk miles to the nearest health post, and are unlikely to have access to a hospital if problems arise during pregnancy and childbirth.

The major causes of maternal

Illegal abortion is a major problem in Paraguay, where abortion is illegal in all circumstances, even to save the life of the mother.

death are post-partum haemorrhage, toxæmia of pregnancy (or pre-eclampsia) and infections. All of these can be treated if the mother can reach antenatal care and hospital services. Unfortunately, most Paraguayan women live too far from health posts or hospitals, and do not have the means to travel to them.

One answer to the problem is to train the midwives to provide a better service to their clients. Maria Vasquez is a midwife who has been practising for 23 years. She has attended courses funded by the Ministry of Health and the Pan American Health Organization (PAHO) so as to upgrade her skills. In a small room beside her home in a working-class barrio of the new city of Ciudad del Este on the Brazilian border, she provides antenatal care, including taking blood pressure, palpating the abdomen to check the baby's size and position, and asking the mother general questions about health. Maria Vasquez attends women in labour and makes sure that women with problems receive the medical attention they need. She also gives information about breast-feeding and acts as a community-based distributor for the Paraguayan Centre for Population

Studies (Centro Paraguayo de Estudios de Población), to help mothers to space their pregnancies.

The lack of adequate family planning services has clearly been a cause of many health problems for Paraguayan women. In 1979, high-level governmental opposition to family planning was expressed, and Ministry of Health officials closed down the government programme which had been run since 1972 with USAID support. In the late 1980s, UNFPA helped to set up a natural family planning project; in 1988 the Ministry began a tentative service as part of its maternal and child health programme.

Today, although contraceptives are available from pharmacies, it is estimated that only about 15% of the population can afford to pay for them. Furthermore, women do not then receive the information they may need to use these methods effectively. Dr Victor Raúl Romero, Director of the government's Maternal and Child Health programme, says, "In 1990 family planning was integrated with maternal and child health services in all health centres." The government is

concentrating on family planning for women under 20 or over 35, and those with four or more children. He adds: "The Ministry is functioning with discretion. This is not a demographic programme; it is necessary for the health of mothers and children – part of the fight against criminal abortion which is responsible for our high maternal mortality rate."

Illegal abortion is a major problem in Paraguay, where abortion is illegal in all circumstances, even to save the life of the mother. It is estimated that illegal abortion accounts for one-third of all maternal deaths in Paraguay, as compared to only a quarter in neighbouring Chile and Argentina. Surveys show that 35% of women in Paraguay have had at least one abortion, and an estimated 26 000 abortions take place every year. As many as 80% of first pregnancies among girls aged 14 to 16 end in abortion. Only 3% of abortions are carried out by doctors, the rest being performed by unskilled abortionists or traditional midwives.

All the same, there is now optimism. The new Health Minister, Cynthia Prieto Conti, is keen to put women's health at a community level. The rapid improvement in human rights and the unmuzzling of the press have enabled community organizations and political parties to campaign freely. With the promised democratization, Paraguay can make rapid strides to modernize itself and provide better health care to all its citizens, women included. ■

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Vaccinations: mothers require motivation

Dominique Tuka-Mbinsi

Three-quarters of mothers do not bring their children to all the vaccination sessions. How can mothers be motivated and mobilized?

Despite the efforts of the health services in Zaïre, immunization coverage leaves much to be desired even today, owing to lack of interest shown by mothers in vaccination sessions. Because of this, nurse educators began a study in February 1991 which has already started to bear fruit. The investigators analysed the records of 2820 children and, in an area of Kinshasa served by eight health centres, they found 1362 unmotivated mothers without means of transport, i.e., 48% of all mothers.

The study showed that all the mothers have adequate knowledge of the six diseases preventable by immunization and that 58% of them understand the purpose of vaccination, but about three-quarters of them do not bring their children to all the vaccination sessions. Among the reasons given were lack of time, no money to pay for transport, too much work, bad weather and illness; thus, the substantial resources devoted to education (through songs, pictures, radio and television) have not yet succeeded in motivating the mothers sufficiently.

There is therefore a need to look for deeper causes, particularly sociocultural factors in Zaïrean society. Many people believe that diseases – even infectious ones – are caused by witchcraft or spells, infidelity, the wrath of ancestors, sins,



Vaccination in Kenya. Half the battle is to motivate the mothers.

disobedience to God and divine punishment. Such beliefs may reduce confidence in health activities such as vaccination, and matters are made worse by the difficult socioeconomic situation of a great number of these mothers, who tend to concentrate on survival activities such as trading, to the detriment of their children's and their own health, but usually with no other choice.

Under these circumstances, how can mothers be motivated and mobilized to attend vaccination sessions? As a result of our contacts with the mothers during the survey, we can suggest three specific approaches.

- For example, 79% of the women asked for an *incentive bonus*. We noticed during the survey that women who had been given pictures about vaccination or diarrhoea showed more confidence and regarded these pictures as a "certificate of encouragement".
- A second approach would be to make *more visits* and hold

vaccination sessions nearer their homes. This proposal, made by 54% of the women questioned, calls for logistic and financial resources. The mobile health teams could be strengthened so as to perform vaccinations in schools, markets and other community meeting-places.

- A third idea would be to incorporate a *spiritual dimension* in health education programmes. This would help to remove barriers created by the psychospiritual factors listed above and to tap the spiritual resources of the mothers, making them receptive to health activities and motivating them to accept the necessary changes. ■

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Quality care in the South Pacific

Ruth Stark & N. Ngapoko Short



A nurse practitioner working on the outer island of Penrhyn, Cook Islands.

Specially trained nurse practitioners are bringing health care to residents of the far-flung Cook Islands.

It is no easy thing to bring quality health services to remote island communities, but health officials in the Cook Islands have found a way. In collaboration with WHO, the government has given six experienced nurses a special one-year nurse practitioner course to prepare them to work on remote islands in the South Pacific where there are no doctors.

Well over half of the Cook Islands' 19 000 people live on Rarotonga, where they have access to hospital and public health services. But the rest live on 11 small islands scattered over 800 000 square miles of ocean.

The newly trained nurse practitioners are now working on five of the outer islands, where radio contact enables them to consult with the doctors in Rarotonga. These women have learned to diagnose and treat common health problems, deliver babies and handle emergencies. Most importantly, they have learned how to tell when a patient is seriously ill and needs a doctor's care.

We visited some of these young women to see for ourselves how they were working. A four-hour flight brought us to Manihiki. There we observed the nurse practitioner, Moeroa Mokoha, caring for patients in the clinic and making a home visit. The people told us that they felt safe when Moeroa was on the island, and that just talking to her made them feel good.

Reaching Rakahanga required a three-hour ride on rough seas in an open 12-foot aluminium boat. Nurse practitioner Emily Tuteru was caring for a seriously ill patient. She diagnosed acute appendicitis, and contacted the surgeon in Rarotonga by radio. The surgeon agreed with the diagnosis, and the patient was started on intravenous antibiotics until he could be evacuated for emergency surgery. Emily cared for the patient through the night.

The next day we managed to transport the patient by boat to Manihiki, but the plane to Rarotonga was delayed by one day. At that point, Moeroa relieved the exhausted Emily and stayed at the patient's bedside through the long night. He was finally taken to the waiting plane in the only available vehicle – a tractor! Four hours later he was admitted to the Rarotonga Hospital. Timely nursing care had saved his life. ■

Dr Ruth Stark is a Nurse Educator/Administrator in WHO's Western Pacific Region, and Mrs N. Ngapoko Short is Director of Nursing in the Cook Islands. Dr Stark's address is WHO, P.O. Box 113, Suva, Fiji.

Ideas for action

Bolivia's *promotores*

Joseph W. Bastien

To be successful, community health workers have to be actively involved with the people they serve and among whom they live.

The training of community health workers to work in the Department of Oruro, Bolivia, was started by Project Concern and the Ministry of Health during 1982. The community was educated about the need for public health measures and the role of the community health workers – *promotores*. The people then elected local peasant farmers to fill this role, preferring them to religious proselytizers, who are openly opposed to traditional medicine. The farmers were given two-week training courses each month for three months with instruction in the native languages of Aymara and Quechua. They learn not only about the use of medicinal plants but also about primary health care, the construction of latrines, stoves, and greenhouses, and crop improvement.

By 1985, 46 community health workers were working effectively in Oruro. Most of them had built greenhouses, ovens and latrines. They maintained rudimentary dispensaries and were active in mothers' clubs. Most significantly, they had become leaders in their communities.



A wedding in rural Bolivia. The *promotores* know how to take vital cultural and religious factors into account.

Regrettably, doctors and auxiliary nurses rarely visited them and provided little support. The community health workers felt they were on the bottom rung of the health ladder. Doctors who were supportive of the programme were assigned to supervise their work.

Community health workers are not

paid wages, nor do they receive remuneration in kind. When they complained about this, we suggested that they use *ayni* or exchange of services. For example, if they cannot tend their flocks or take care of their fields because they are administering to the sick, other members of the community should stand in for them.

Remote rural community

Celestino Lara is 36 years old and a native of Sora Sora, a community of 750 people. His tasks have included fighting against tuberculosis, growing vegetables, preserving produce, providing veterinary services, and coordinating modern and traditional medicine. When he became a *promotor* in 1984, Sora Sora was a rural community of about 150 families who live in tiny adobe houses with straw roofs and no windows. There was no road, and so trucks were unable to bring in supplies. The people had to walk or cycle to Totora, 21 kilometres away, where the nearest health worker, an auxiliary nurse, was stationed. The infant mortality rate was estimated to be 260 per 1000 live births, many deaths occurring because of diarrhoea, neonatal tetanus, and acute respiratory infections. Tuberculosis debilitated the majority of adults and caused early death; the average life span was only 30 years.

When Celestino began attending the training course for community health workers in 1984, he was timid and a slow learner. He completed the course, but its directors doubted whether he would accomplish anything. The organizers viewed leadership in a "Western" light and scarcely appreciated that the Aymaras, on the other hand, were inclined to regard it as being embedded in the cosmological (ritualistic) and social life of the community. Participants, for example, were uncomfortable with competition and with awards for outstanding students, because they were very sensitive to group consensus and attitudes.

Celestino helped the organizers to realize that, instead of training community health workers to stand out from the community, they should be encouraged to immerse themselves deeper into its social, cultural and religious life. However, many candidates still see the job as a step towards becoming an auxiliary nurse and leaving the community. Consequently, ambition has to be carefully evaluated. Celestino was able to introduce many valuable

changes through his selfless involvement in the life of his village.

After he finished his training and returned to Sora Sora, his wife became sick. He thought someone had bewitched her and asked a *curandero* (local healer) to effect a cure with rituals and medicinal plants, but this proved unsuccessful. He then took her to the hospital in Totora, where



Guatemala: a trained auxiliary nurse monitors children's growth and development

pulmonary tuberculosis was diagnosed and antibiotics were supplied to Celestino for the year-long treatment. After five months she reacted to the medicine with peeling skin and swelling of the body. Relatives criticized him for having used this medicine on his wife, but he was determined to finish the treatment. His wife's family would not speak to him and threatened punishment if she died. By the ninth month she had recovered and her relatives and the rest of the community then accepted him as a healer.

Expanding activities

By 1986 he had treated many more patients with tuberculosis and, indeed, had begun eradicating the disease from his village. He also conducted a child immunization programme against tuberculosis and other diseases. At his suggestion, the villagers formed health, agricultural, and education committees; they also asked the Ministry of Rural Health to train Celestino in suturing wounds and treating complicated diseases.

Celestino was one of the first community health workers to collaborate with traditional healers. He recognizes his limitations and their contributions to health. He refers pregnant women to a midwife *curandera* for delivery, and has taught her about sterilization methods.

For many years the people suffered from malnutrition because they lacked vegetables, which could only be obtained by travelling long distances. In 1985 Celestino introduced underground hothouses to the village, and within two years every family in the community was growing tomatoes, carrots, radishes and turnips. There is now a surplus of vegetables, some of which are sold in a weekly market.

As a tribute to his efforts the villagers asked that he be trained as an auxiliary nurse, and agreed to pay his salary after he qualified. They also decided to build a health post.

Celestino qualified as an auxiliary nurse in 1987, and the health post was then inaugurated.

Today Celestino is committed to working for health, increased productivity, and the integration of modern and traditional medicine. He has helped to give life to a dying community and demonstrates just how effective community health workers can be. ■

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WHO in action

Overcoming iodine deficiency

Salt industry representatives and government officials from eight southern African countries sat down together in Francistown, Botswana, last April to decide how to ensure that all salt consumed in the region is

iodinated at the production source. In addition, they reached agreement on appropriate levels of iodine and suitable packaging to ensure iodine retention even after salt has been transported over great distances or stored for long periods. The Botswana Company, which began salt production only last year, has agreed

to assume the cost of iodinating all the salt for human and animal consumption which it will soon be supplying to some ten countries in southern and central Africa.

Adding a minuscule quantity of iodine to salt is the standard and proven long-term strategy for controlling iodine-deficiency disorders (IDD). The unnecessary and often tragic consequences of a deficiency of this vital micronutrient include endemic goitre and cretinism; retardation of physical and mental development; impaired school performance and work capacity; and increased rates of abortion, stillbirth, congenital anomalies, and perinatal, infant and child mortality. The World Summit for Children, held in New York in 1990, recognized the magnitude and seriousness of the problem and adopted, as the target for the international nutrition community, the virtual elimination of these disorders globally by the end of the present decade.

Responding to a need for dialogue between salt producers and importing countries on how to ensure that all salt distributed in the region is iodinated at an appropriate level at the production source, the government of Botswana convened the first workshop of its kind. It received support from the International Council for Control of Iodine Deficiency Disorders, UNICEF, WHO, the Canadian International Development Agency and the International Life Sciences Institute. Each of the eight participating governments – Botswana, Lesotho, Malawi, Mozambique, Namibia, Zaire, Zambia and Zimbabwe – sent tripartite delegations representing commerce, health and information. The 60 participants also included representatives of the region's major salt companies.

The workshop's objectives were to acquaint key persons in the governments of salt-importing and IDD-affected countries with the steps



Physical and mental development may be affected by iodine deficiency; children need to be protected.

needed to ensure effective salt iodination programmes, and to achieve consensus on key issues relating to the importation and use of iodinated salt to eliminate IDD. Discussions focused on promoting consumption of iodinated salt by the general population, iodine dosage levels, quality control and verification, packaging requirements, legislative measures for adoption by importing countries, and the monitoring of salt iodine levels at various points during importation and distribution.

The workshop concluded that the main constraints retarding effective salt iodination were: the combined lack of up-to-date information on IDD, dialogue between the public and private sectors, and clear guidelines on iodination levels; weak legislation; non-availability of salt-consumption figures; the presence of many small salt producers who make it difficult to ensure uniformity and compliance; little or no quality verification capability; and a lack of clear guidelines for standardized packaging and labelling.

Participants considered communication to be crucial for the success of IDD prevention and control programmes. They stressed the need

to create awareness among the groups and individuals concerned, including political leaders, policy- and decision-makers, salt producers, wholesalers and retailers, and consumers. If IDD prevention programmes are to succeed, they should include the direct participation of salt producers in drawing up regulations and specifications on such matters as iodine levels and product packaging and labelling.

The main recommendations emerging from the workshop were that:

- governments should include IDD prevention measures in their national plans of action for achieving the goal of virtual elimination of IDD;
- an adequate communications strategy is an urgent necessity for all existing iodinated salt programmes in southern Africa;
- programmes should be supported by adequate systems for monitoring salt distribution and iodine levels, appropriate legislation and regulations, training and continuing operational research;
- there should be open dialogue between health-sector IDD



Prevention measures must reach all the population.



Communication strategies include health education of the public.

management teams, the commerce, agriculture and other sectors involved, and the salt industry (this should include drawing up specifications for salt quality and regulations on iodinated salt, as well as evaluating the programmes);

- salt producers should participate actively as essential partners in national IDD management systems;
- international, bilateral, regional and other governmental and private agencies should accelerate their activities in support of the goals of the World Summit for Children, including encouraging national efforts to eliminate micronutrient malnutrition and setting up systems to monitor progress towards the elimination of IDD by the year 2000. ■

WHO on . . .

New role of nurses and midwives

National strategies for Health for All cannot be effectively carried out without the participation of nurses and midwives. This was the conclusion of a resolution that was approved by all Member country delegates attending the Forty-fifth World Health Assembly in May 1992. This resolution states that it is urgent to better utilize the important contribution of nurses and midwives in primary health care. The resolution expressed concern at the present decline in the numbers of nurses and midwives all over the world and the low profile of their work. Their education, practice and involvement in health care policy should be given urgent attention by all countries.

The skills of nurses and midwives are more and more crucial to effective and efficient health services in four major areas: (1) preventive care, (2) curative care, (3) chronic and rehabilitative care, and (4) high dependency-care and care of the dying. In addition, they often act in the

same four areas as coordinators of the care provided by physicians and other health professionals. They also train health professionals and supervise auxiliary workers. Some 5–10% of nurses are men.

Health promotion and disease prevention are closely interwoven in the work of nurses and midwives. They also have a crucial role in

reducing neonatal and maternal mortality, and preventing birth-related complications, as well as in school and occupational health. In many countries they are the primary caregivers in communities, in particular for the most vulnerable people – the urban poor, remote rural populations, mothers and children, the elderly and the chronically ill.

Carers and facilitators

Nurses and midwives are front-line workers in many countries, working in the communities where they diagnose and treat a wide range of common health problems. Throughout the world the majority of them work in all levels of hospitals, including those where advanced medical technology makes highly skilled nursing care essential to the survival and recovery of the patients.

Increasingly, nurses see themselves as facilitators so that people – especially the chronically ill of all ages, the mentally impaired and the elderly – can participate actively in their own care and health development, and attain an optimal quality of life. Since the chronically ill may continue for many years in a state of complete dependency, there is a rapidly growing need for home care by nurses, as well as support to families that give such care or are in situations of distress (after a child's death or a suicide, for example). The AIDS pandemic, too, has multiplied the need for nursing care. Again, nurses are ideally placed to provide guidance and support in managing the disease and living with its consequences. ■

Miriam J. Hirschfeld,
Chief of the Nursing Unit in WHO.

Give blood for love

Whatever their particular reasons for being donors, people give their blood because they care for other people and because they know that it will save lives.

Why give blood?

A serious illness in the family or among close friends may raise the consciousness in people about blood donation. Few of us realize that a continuous supply of blood is essential to keep many otherwise life-threatening conditions in check. For example, a healthy teenage boy with haemophilia A needs on average (not counting accidents, surgery or other high-consumption incidents) 50 000 units of factor VIII a year. It takes 20 blood donors to provide 1000 units, so it's not difficult to see that it needs 1000 public-spirited people to keep just one haemophiliac going for a year.

The motive for giving blood is idealistic, a desire to help! Purely altruistic reasons are common. After donation, even the coffee tastes especially good and the nurses of the blood service seem pretty and kind. It is also good to get a health check-up once in a while as you do at the donation.

Blood donation is a partnership
between the donor and the blood

service. Motives which are competitive or egoistic blur the real spirit of it and may lead to harm, just as compensation in money may do. There may be a temptation to hide factors that would limit the ability to donate. Partnership means that the blood service must be able to ensure the safety of not only the one who receives blood but also the one who gives it. The donor's cooperation is needed for this.

The blood service must have credibility among both the donors and users of blood. Its work must be of top quality, its products safe and efficacious, and its moral and ethical base solid. Only then will the voluntary non-remunerated blood donor keep coming back. Only then can a stable supply of blood be guaranteed for the treatment of patients. ■

Jukka Koistinen
Health Laboratory Technology
and Blood Safety Unit in WHO.

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In the next issue

Health issues and economic development are closely interwoven and no area of development can succeed without substantial improvement in the field of public health. Health, in turn, benefits greatly from economic development. The November-December issue of *World Health* will study several aspects of this important subject. ■

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